

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968653</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/15/2020</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SOUTHERN LIVING OF TITUSVILLE**

**2375 JAY JAY RD  
TITUSVILLE, FL 32796**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A re-licensure survey with Extended Congregate Care (ECC) was conducted at Southern Living of Titusville on . Deficiencies were identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | A 000               |                                                                                                                          |                          |
| A 008<br>SS=D            | 429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.<br>(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a | A 008               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| A 008                    | Continued From page 1<br><br>permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.<br><br>(6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The | A 008               |                                                                                                                          |                          |

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| A 008                    | <p>Continued From page 2</p> <p>applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of _____ require such assistance.</p> <p>59A-36.006<br/>(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a _____-to-_____ medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection.<br/>(a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following:<br/>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,<br/>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,<br/>3. Any nursing or _____ services required by the individual,<br/>4. Any special diet required by the individual,<br/>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,<br/>6. Whether the individual has signs or symptoms of _____ or any other communicable _____, which are likely to be transmitted to other residents or staff,<br/>7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and,<br/>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care</p> | A 008               |                                                                                                                          |                          |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHERN LIVING OF TITUSVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2375 JAY JAY RD<br/>TITUSVILLE, FL 32796</b>                                 |  |                                                        |
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| A 008                                                                    | <p>Continued From page 3</p> <p>provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.</p> <p>(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-09170">http://www.flrules.org/Gateway/reference.asp?No=Ref-09170</a>. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.</p> <p>1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.</p> <p>2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.</p> <p>3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.</p> <p>(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission.</p> <p>(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with</p> | A 008                                                                          |                                                                                                                          |  |                                                        |

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| A 008                    | <p>Continued From page 4</p> <p>either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).</p> <p>(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule.</p> <p>(f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of _____ or _____.</p> <p>(g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.</p> <p>This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the 1823 health assessment form was complete for 2 of 2 sampled residents (#3 and #4).</p> | A 008               |                                                                                                                          |                          |

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| A 008                    | Continued From page 5<br><br>Findings:<br><br>1. Review of resident #3's current 1823, dated _____, revealed the question on the form that asked whether or not the resident's needs could be met in an Assisted Living Facility was not answered. (photographic evidence obtained.)<br><br>2. Review of resident #4's current 1823, dated _____, revealed the form was missing the examiner's address and telephone number. (photographic evidence obtained.)<br><br>Neither resident's record contained documentation to indicate a health care provider was contacted to obtain the omitted information.<br><br>On _____ at 2:50 p.m. the administrator confirmed the findings and was unable to provide additional documentation.<br><br>Class III | A 008               |                                                                                                                          |                          |
| A 010<br>SS=D            | 429.26( _____ &9) FS; 59A-36.006(4) FAC<br>Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held                                                                         | A 010               |                                                                                                                          |                          |

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| A 010                    | <p>Continued From page 6</p> <p>by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.</p> <p>(2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.</p> <p>(9) A . . . , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.</p> <p>59A-36.006</p> <p>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in</p> | A 010               |                                                                                                                          |                          |

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| A 010                                                                    | <p>Continued From page 7</p> <p>paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:</p> <p>(a) The resident may be bedridden for no more than 7 consecutive days.</p> <p>(b) A resident requiring care of a _____ may be retained provided that:</p> <ol style="list-style-type: none"> <li>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider;</li> <li>2. The condition is documented in the resident's record; and,</li> <li>3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility.</li> </ol> <p>(c) A _____, ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;</li> <li>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;</li> <li>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,</li> <li>4. Documentation of the requirements of this paragraph is maintained in the resident's file.</li> </ol> <p>(d) The facility administrator is responsible for</p> | A 010                                                                          |                                                                                                                          |                          |                                                        |



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| A 010                    | <p>Continued From page 8</p> <p>monitoring the continued appropriateness of placement of a resident in the facility at all times.</p> <p>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.</p> <p>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.</p> <p>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record reviews and interview, the facility failed to ensure an interdisciplinary care plan was developed and implemented for 2 of 2 sampled residents (#3 and #4) who received hospice services.</p> <p>Findings:</p> <p>1. Review of resident #3's record revealed a hospice admission date of . . . . .</p> <p>2. Review of resident #4's record revealed she was admitted to the facility on . . . . . under hospice services.</p> <p>Neither resident's record contained documented evidence of an interdisciplinary care plan, as required.</p> <p>On . . . . . at 2:50 p.m. the administrator confirmed the findings and was unable to provide</p> | A 010               |                                                                                                                          |                          |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968653</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/15/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHERN LIVING OF TITUSVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2375 JAY JAY RD<br/>TITUSVILLE, FL 32796</b>                                 |                          |                                                        |
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| A 010                                                                    | Continued From page 9<br><br>additional documentation.<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A 010                                                                          |                                                                                                                          |                          |                                                        |
| A 032<br>SS=D                                                            | 59A-36.007(8) FAC Resident Care - Elopement<br>Standards<br><br>59A-36.007<br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement.<br>All residents assessed at risk for elopement or<br>with any history of elopement must be identified<br>so staff can be alerted to their needs for support<br>and supervision. All residents must be assessed<br>for risk of elopement by a health care provider or<br>a mental health care provider within 30 calendar<br>days of being admitted to a facility. If the resident<br>has had a health assessment performed prior to<br>admission pursuant to paragraph 59A-36.006(2)<br>(a), F.A.C., this requirement is satisfied. A<br>resident placed in a facility on a temporary<br>emergency basis by the Department of Children<br>and Families pursuant to section 415.105 or<br>415.1051, F.S., is exempt from this requirement<br>for up to 30 days.<br>1. As part of its resident elopement response<br>policies and procedures, the facility must make,<br>at a minimum, a daily effort to determine that at<br>risk residents have identification on their persons<br>that includes their name and the facility's name,<br>address, and telephone number. Staff trained<br>pursuant to paragraph 59A-36.011(10)(a) or (c),<br>F.A.C., must be generally aware of the location of<br>all residents assessed at high risk for elopement<br>at all times.<br>2. The facility must have a photo identification of<br>at risk residents on file that is accessible to all<br>facility staff and law enforcement as necessary.<br>The facility's file must contain the resident's photo | A 032                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHERN LIVING OF TITUSVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2375 JAY JAY RD<br/>TITUSVILLE, FL 32796</b>                                 |  |                                                        |
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| A 032                                                                    | <p>Continued From page 10</p> <p>identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.</p> <p>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:</p> <ol style="list-style-type: none"> <li>1. An immediate search of the facility and premises,</li> <li>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,</li> <li>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,</li> <li>4. The continued care of all residents within the facility in the event of an elopement.</li> </ol> <p>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(i), F.S.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on facility record reviews and interviews, the facility failed to conduct a minimum of two resident elopement prevention and response drills per year.</p> <p>Findings:</p> <p>On . . . . . at 10:39 a.m. caregiver C said she'd only ever participated in one elopement drill.</p> | A 032                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SOUTHERN LIVING OF TITUSVILLE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2375 JAY JAY RD<br/>TITUSVILLE, FL 32796</b> |                                                                                                                          |
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| A 032                                                                    | <p>Continued From page 11</p> <p>Review of caregiver C's personnel record revealed she was hired on . . . . .</p> <p>Review of the facility's elopement drill binder, which was provided by the administrator, revealed it contained documentation to indicate an elopement drill was conducted only once in 2019 on . . . . . and once in 2018 on . . . . .</p> <p>On . . . . . at 2:45 p.m. the administrator confirmed the findings and was unable to provide additional documentation.</p> <p>Class III</p> <p>A 162<br/>SS=D</p> <p>59A-36.015(3) FAC Records - Resident</p> <p>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:</p> <p>(a) Resident demographic data as follows:</p> <ol style="list-style-type: none"> <li>1. Name,</li> <li>2. . . . .</li> <li>3. Race,</li> <li>4. Date of birth,</li> <li>5. Place of birth, if known,</li> <li>6. Social security number,</li> <li>7. Medicaid and/or Medicare number, or name of other health insurance . . . . .</li> <li>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,</li> <li>9. Name, address, and telephone number of the health care provider and case manager, if applicable.</li> </ol> <p>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.</p> | A 032                                                                                    |                                                                                                                          |
|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | A 162                                                                                    |                                                                                                                          |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SOUTHERN LIVING OF TITUSVILLE**

**2375 JAY JAY RD  
TITUSVILLE, FL 32796**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 162                    | <p>Continued From page 12</p> <p>(c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.</p> <p>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.</p> <p>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.</p> <p>(f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.</p> <p>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.</p> <p>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.</p> <p>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.</p> <p>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.</p> <p>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property</p> | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| A 162                                                                    | <p>Continued From page 13</p> <p>disbursed as required in section 429.27, F.S.</p> <p>(l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____, _____, CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a>. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <ol style="list-style-type: none"> <li>1. A log listing the names of residents participating in this arrangement,</li> <li>2. The resident demographic data required in this paragraph,</li> <li>3. The health assessment described in rule 59A-36.006, F.A.C.,</li> <li>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</li> </ol> | A 162                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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| A 162                    | <p>Continued From page 14</p> <p>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observations, record reviews and interviews, the facility failed to document in the care record of 1 of 2 sampled residents (#4) who experienced a significant change.</p> <p>Findings:</p> <p>Review of resident #4's record revealed a facility admission date of _____.</p> <p>A facility admission note, dated _____, indicated that her _____ were red, and the skin was intact.</p> <p>Review of the resident's current 1823 health assessment form, dated _____, revealed the question that asked whether the resident had any _____, 3 or 4, _____ was answered as no.</p> <p>A hospice nurse's visit note, dated _____,</p> | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968653</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/15/2020</b> |
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| A 162                    | <p>Continued From page 15</p> <p>indicated the resident had a _____ on her left _____ that measured 2 cm. x 2 cm. with surrounding _____ and 100% _____. The note did not indicate the staging of the _____.</p> <p>Observations made on _____ at 11:30 a.m. revealed the resident had a _____ measuring approximately 5 cm. x 2 cm. on her right inner _____, a _____ measuring approximately 3 cm. x 1 cm. on her left inner _____ and a _____ measuring approximately 1 cm. x 1 cm. also on her left inner _____.</p> <p>Review of the resident's record revealed it did not contain facility documentation of the onset of the _____.</p> <p>On _____ at 11:50 a.m. the administrator said she knew the resident had _____ on her _____ and said, "but it's just a scrape and it's not open."</p> <p>On _____ at 12:10 p.m. the administrator was unable to locate any facility documentation regarding the _____ in either the resident's record or elsewhere.</p> <p>On _____ at 12:28 p.m. the hospice nurse who authored the _____ note said that at the time of that visit, there was one _____ which was described in her note.</p> <p>Class III</p> | A 162               |                                                                                                                          |                          |